

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

File No. 123283-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 18th day of January 2012
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On September 9, 2011, XXXXX (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On September 16, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request.

The Petitioner receives group health care benefits under a plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Commissioner notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Commissioner received BCBSM's response on September 19, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). *Rider CBD \$2000-NP Community Blue Deductible Requirement for Nonpanel Services* (the rider) also applies. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On October 2, 2009, the Petitioner went to the emergency department of the XXXXX Hospital after she experienced a severe headache. Because her nausea and pain continued, she

was kept in the hospital for continued monitoring. On October 3 and 4 the Petitioner had follow-up care from XXXXX, MD. Although Dr. XXXXX participates with BCBSM, he is not a panel provider under the Petitioner's PPO program.¹

Dr. XXXXX submitted claims totaling \$473.00 for the Petitioner's care in the hospital care and discharge. BCBSM's approved amount for that care was \$220.28 which Dr. XXXXX agreed to accept because he is a participating provider with BCBSM. However, since Dr. XXXXX is a nonpanel provider, BCBSM applied the \$220.28 to the Petitioner's nonpanel deductible.

Petitioner appealed BCBSM's application of the deductible to the care provided by Dr. XXXXX. BCBSM held a managerial-level conference on July 27, 2011, and issued a final adverse determination dated August 3, 2011, upholding its position.

III. ISSUE

Did BCBSM correctly process the claims for Dr. XXXXX's care?

IV. ANALYSIS

BCBSM's Argument

BCBSM says it paid its allowed amount for the emergency department visit and related hospital charges. However, because Dr. XXXXX is a nonpanel provider, the allowed amount for his services was applied to the nonpanel deductible as required by the rider. In its August 3, 2011 final adverse determination BCBSM told the Petitioner:

You are covered by the *Community Blue Group Benefits Certificate*, which is amended by *Rider CBD \$2000 - Community Blue Deductible Requirement for Nonpanel Services*. This *Rider* explains that you must pay a deductible requirement of \$2000 per member, or \$4000 for the family, each calendar year before payment will be made for covered services received by nonpanel providers.

Dr. XXXXX is a non-panel provider.

The certificate, in "Section 2: What You Must Pay" (p. 2.1), says the Petitioner must pay a deductible each year for services received from nonpanel providers. The rider amended the certificate to increase the nonpanel deductible to \$2,000.00 for one member or \$4,000.00 for the family. The rider also explains when the nonpanel deductible will be waived:

¹ "Nonpanel provider" is defined in the certificate (p. 7.17) as "Hospitals, physicians and other licensed health care professionals who have not signed an agreement to provide services under this PPO program."

You are not required to pay a deductible for covered nonpanel services when:

- A panel provider refers you to a nonpanel provider

NOTE: You must obtain the referral **before** receiving the referred service or the service will be subject to nonpanel deductible requirements.

- You receive services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider that has no PPO panel
- You receive services from a nonpanel provider in a geographic area in Michigan deemed a "low access area" by BCBSM for that particular provider specialty

BCBSM says none of the exceptions apply in the Petitioner's case and that it correctly processed the claims for Dr. XXXXX's services.

Petitioner's Argument

The Petitioner believes that she was misled about what she needed to do to avoid out-of-pocket expenses. She says that BCBSM applied the approved amount for Dr. XXXXX's care to the deductible because he was a nonpanel doctor and she did not have a referral from a panel doctor. She says several times she asked the facility to obtain any and all needed referrals. She further says that she told the facility that she did not want services that would not be covered and they told her that the facility and the providers were in-network with BCBSM.

She would like BCBSM to cover her care without applying the nonpanel deductible. Since the care she received was related to her emergency room care she does not believe she should be required to pay such a large amount.

Commissioner's Review

The Commissioner concludes that BCBSM correctly processed the claims for Dr. XXXXX's services.

The certificate and rider are clear: When services are received from a nonpanel provider, the nonpanel deductible must be met. There is no dispute that Dr. XXXXX is not a panel provider and the record does not show that any of the exceptions in the rider were met:

- There is no documentation that the Petitioner had a referral from a panel doctor.
- Dr. XXXXX's care was not part of the emergency department treatment. His services were billed with CPT codes 99232 and 99231 ("subsequent hospital care") and CPT code 99238 ("hospital discharge day management"). None of those services are emergency services.
- There is no showing that the services were from a provider that has no PPO panel.
- The services were not received in a geographic area in Michigan deemed a "low access area" by BCBSM for that particular provider specialty.

While it is unfortunate that the Petitioner received services from a nonpanel physician, apparently unknowingly, nothing in the certificate or in state law requires BCBSM to waive the nonpanel deductible in this case.

V. ORDER

Blue Cross Blue Shield of Michigan's August 3, 2011, final adverse determination is upheld. BCBSM is not required to waive the nonpanel deductible in this case.

This is a final decision of an administrative agency. Under MCL 550.1915(1), any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner